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# Hospital Bill Payment Receipt

**Hospital Name:** City Health Hospital

**Hospital Address:** 123 Health Avenue, Metropolis, State, Zip Code

**Phone:** (123) 456-7890

**Date:** May 16, 2024

**Receipt Number:** 987654321

## Patient Information:

**Name:** John Doe

**Patient ID:** 001234567

**Date of Birth:** 01/01/1980

**Address:** 456 Patient Street, Anytown, State, Zip Code

## Billing Information:

**Bill Issue Date:** May 10, 2024

**Service Period:** April 20, 2024 - May 10, 2024

**Due Date:** May 15, 2024

## Payment Details:

**Total Charges:** \$2,500.00

**Amount Paid:** \$2,500.00

**Payment Method:** Credit Card

**Transaction ID:** 123456789ABC

## Services Provided:

- Emergency Room Visit: \$1,000.00
- X-Ray: \$300.00
- Blood Tests: \$200.00

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- Overnight Stay: \$1,000.00

**Amount Due:** \$0.00

**Notes:**

Thank you for your prompt payment. This receipt confirms that we have received the full payment for the services provided. Please keep this receipt for your records.

If you have any questions or concerns about this receipt or the services rendered, please contact our billing department at (123) 456-7890.

**Authorized Signature:**

[Digital or Physical Signature]

**Printed Name:** Jane Smith

**Title:** Billing Officer

**Date:** May 16, 2024